

Jelks (J. J.)

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MEDICUS

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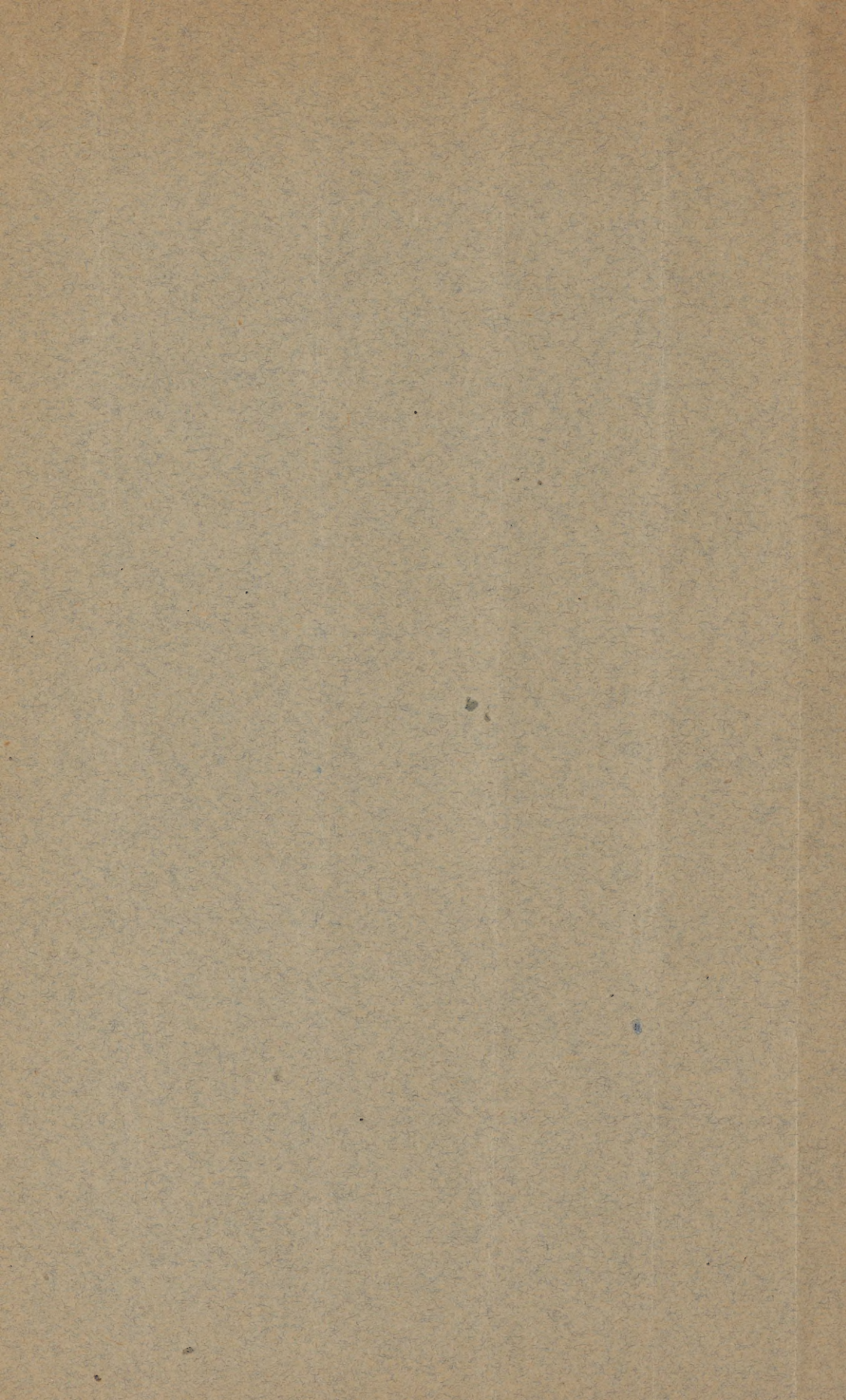
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SOME EFFECTS OF BLENNORRHOEA IN WOMEN.¹

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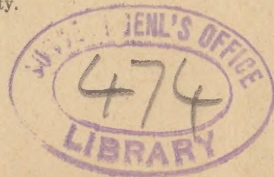
I do not mean to discuss blennorrhœa in women in all its details, but desire to call the attention of the members of this society to some of its results.

Last spring I was called to see Mrs. Blank; I was treating her husband at the time for an attack of blennorrhœa which he had contracted some time previously.

He, thinking he was quite well, had indulged in coitus with his wife and had infected her. She passed through the usual symptoms of this disease. For several months previous to calling me she had pain in the region of both tubes. When I saw her I diagnosed salpingitis gonorrhœica. I found both tubes enlarged and tender on bi-manual manipulation. Advised her to stay in bed and use hot vaginal douches for thirty minutes night and morning, with iodine to the abdomen. She disobeyed my instructions, got up from the bed and lifted some article of furniture. Immediately there was great pain in the abdomen, and when I reached her she was in collapse, with the neighbors around her rubbing her, giving hot foot baths, whisky, etc. I diagnosed a leaking Fallopian tube and rapidly developing general peritonitis.

I gave her a hot vaginal douche at 110° for thirty minutes, and ordered half a glass of a saturated solution of sulphate of magnesia every hour until she was purged from seven to ten times. This was accomplished in a few hours, with complete subsidence of all the bad symptoms in twenty-four hours, though the patient was confined to bed for ten days longer. During this time she had the hot vaginal douches night and morning. In two weeks she was up and about the house. The tubes were still tender, but by the use of hot water and Churchill's tinc-

1. Read before the Southern Surgical and Gynecological Society.



ture of iodine to the vaginal vault for one month she was well enough to be dismissed. She is now about as well as usual before the attack of peritonitis developed, and has passed through the summer with so much comfort that she does not now believe she has pus tubes within her. She is symptomatically cured.

In September I was called to see Mrs. Blank, found her in bed with urethritis and complaining much of the frequency of micturition and its painfulness, together with leucorrhœa of recent origin. For this I prescribed as usual. A few days later I was summoned in haste and found her in a state of great collapse, pulse very weak and thready and scarcely to be counted, with great pain in the abdomen, radiating from the left inguinal region and rapidly involving the whole abdomen. I diagnosed peritonitis from extension of existing inflammation, and ordered saturated solution of Epsom salts, a wine glass full every hour until it purged ten times. This was at 9 o'clock; at 10:30 I returned to the case and found she had been vomiting everything given her. I then gave an eighth grain of morphine with 1-150 of a grain of atropia to quiet the stomach; the saline cathartic was continued in tablespoonful doses of the salts dissolved in just enough hot water to hold it in solution. She retained several doses of this and when I returned next morning she had been purged some ten or twelve times, with complete relief of all her symptoms of general pain and collapse. For some days there existed tenderness over the left Fallopian tube, and once she was threatened with a relapse, but a prompt purge with the saline relieved her. She undoubtedly had an attack of peritonitis, which produced profound depression, great pain and tenderness of the abdomen. The track of this inflammation was no doubt through the uterus and tubes. It was aborted by the saline cathartic and the woman is to-day as well as usual.

In case of Mrs. B——, which I reported to the Arkansas State Medical Society last spring, I found the tube on left side enlarged and tender, and producing painful sciatica, as well as pain in the tube and pelvis. In this case I aspirated the enlarged tube and took away about two ounces of pus and drained the cavity. She made a good recovery and has remained well ever since. Her husband had been treated by myself for blennorrhœa.

We here have a report of three cases in which there was infection of the tubes and in two of the cases an extension of the inflammation to the peritoneal cavity, with lighting up of a rapidly spreading septic peritonitis. In one case the trouble was confined to the tube.

As chairman of the section of obstetrics and gynecology of the State Medical Society of Arkansas, I read at the annual session of the society, held in Hot Springs in May last, an article on salpingitis.

I divided the disease into several classes, and traced each to its prime cause, following the method of Sanger, of Leipsic. According to

Sanger the disease may be divided into salpingitis gonorrhœica, actinomycetia, tuberculosa, syphilitica and septica. This latter class does duty for all those cases which are produced by the various classes of germs which may be carried into the uterus by the use of unclean sounds and probes in the hands of the physician. In that paper I called attention to the fact that the term "pelvic cellulitis" of Emmet was a misnomer; that the latter disease is very rare and, practically speaking, never found outside of puerperal cases. Salpingitis, then, is the disease we have to contend with in the class of cases we once called "pelvic cellulitis."

While salpingitis may be produced by the bacillus of tuberculosis, by the bacillus of syphilis and by septic germs which are carried into the uterus on the sound, as I have myself demonstrated in my own practice and seen in that of some of my neighbors, yet in the vast majority of cases it may be traced to blennorrhœa as the prime cause.

Noeggerath called our attention to the fact that blennorrhœa was the source of most of the ills which afflict the pelvic organs of woman. He wrote and talked this for some years, but the profession was slow to believe him, and not until a very recent time have we been ready to accept this doctrine. It is true that many of these women do not know that they have ever had blennorrhœa, and it is possible and probable that a careless examination will give no evidence of the disease; but months and even years after the disease has disappeared from the visible mucous membrane, it may still exist in the tubes in the shape of a salpingitis gonorrhœica.

Investigators have failed to find the gonococcus of Neisser in the pus in all the cases examined; but this does not invalidate the fact that this germ is the source of the vast majority of cases of pus tubes. Death from ptomaine poisoning will probably explain the absence of the microbes.

One fact about this variety of inflammation of the tube is that it is not destructive in character, but is limited to the surface of the mucous membrane, or rather, I should say, to the papillary layer. Hence we do not find pus outside of these tubes except as a result of their leakage, and then usually in a pocket. The pus from a gonorrhœa of the tube does not usually produce a septic peritonitis; and it is only when the infection is a mixed one, as, for instance, the gonococcal inflammation is combined with a pus infection; the gonococcus with either the streptococcus or staphylococcus aureus or albus. When this latter is the case, then a leaking tube will set up a general septic peritonitis and call for prompt and energetic means to stay it. Here, by way of parenthesis, I wish to emphasize the value of the purgative treatment of peritonitis. Purge until seven to ten, or even more, liquid evacuations have been obtained. The peritoneal cavity is a vast sac literally covered with the open mouths of lymphatics and thus, when the intes-

tines are purged freely by salines, the call on these lymphatics is urgent and whatever of fluid is in the cavity of the abdomen is rapidly absorbed and the poisonous germs with it. These germs when once in the blood current are promptly destroyed by its phagocytic action.

The laity have a very incorrect idea of the dangerousness of a case of blennorrhœa. We have all heard them say "they did not mind having a case of blennorrhœa any more than a bad cold."

Many men marry when they have a case of chronic blennorrhœa and think nothing of the evils to follow. Again, when a man has once had a case of blennorrhœa involving the deep urethra, with all the glands which open into it, who can say when that man is in a condition for matrimony? There is no discharge from the meatus to warn him. Practically speaking, these men should never marry until repeated irritation of the urethra with nitrate of silver produces pus which is found free from gonococci. While the laity regard this disease as a very trifling affair, yet we know that in men it produces more deaths than syphilis. Now, when we add to the men so destroyed the women who are rendered invalids for life, the women who are cut off by reason of peritonitis caused by pus in the tubes, produced by the gonococcus, we get a faint idea of the terrible ravages of blennorrhœa.

In the paper read before the Arkansas Medical Society last May, and to which reference has been made above, I called the attention of the profession to the latest "fad" in gynecology, viz.: laparotomy, or, more correctly speaking, cœliotomy, and in doing so I desired to protest against this latest "fad" or craze of the abdominal surgeon. It was fast becoming an axiom with these men, "When in doubt, open the abdomen and see." I have seen many cases of pelvic inflammation, pus in the tubes, get well—symptomatically cured—without a resort to abdominal section. It is true that in the hands of Tait, Price and Beatty, and a *few* others, abdominal section is not a very fatal operation; yet we have few Taites and Prices in this country. But every surgeon who has any pride of opinion—and what surgeon has not—imagines himself as good as anybody else, and, in the effort to rival these distinguished operators, many lives are sacrificed to their unholy ambition. I am not protesting against laparotomy when it is really necessary to save life or restore to health one who is invalided from pelvic disease, but I think these are the only indications. All of you have seen women, in whose tubes you have every reason to believe there was a collection of pus, get symptomatically cured without resort to abdominal section.

As I said above, it is only when the blennorrhagic pus is mixed with some other infecting agent, a mixed infection, that it become dangerous to life. In blennorrhagic pus we have what might very appropriately be called aseptic pus; when it gets into the pelvic cavity from a leaking tube it is promptly encysted and rendered harmless to

the patient, so far as danger to life is concerned; not so, however, if there is at the same time a mixed infection.

I cannot close this paper better than by calling your attention to the recent opinions of some of our writers and operators.

The Cincinnati Lancet-Clinic of recent date says: "Of 122 deaths from surgical procedures in New York City, 33 are credited to laparotomy." In a recent discussion in the New York Academy of Medicine on "Ultimate Results of Laparotomy for Diseases of the Uterine Appendages," Dr. H. C. Coe called attention to the fact that it was said that 10 per cent. of all women whose appendages had been removed, became insane; add this 10 per cent. to the death rate of say 10 per cent., and these operators have a dreadful account to settle with outraged nature. Dr. C. C. Lee had never seen hystero-epilepsy cured by the removal of the uterine appendages. Dr. H. T. Hanks expressed about the same conclusions. Drs. A. P. Dudley and E. H. Grandin agreed with the preceding gentlemen. Dr. McLean had seen many patients whose appendages had been removed still suffering with chronic pelvic inflammation, and some of them with a profound melancholia which nothing could relieve.

Dr. W. T. Lusk said the more he saw of these cases the less inclined he was to remove or advise the removal of swollen tubes; he was dissatisfied with the result of operative procedures, and summed up his opinion thus: "That three out of every four of these cases would get well without operative procedures." Drs. Corcoran and Skene, and Byrne, of Brooklyn, agree with the above opinions in the main.

Other writers, as A. W. Johnston, of Cincinnati, and W. H. Wathen, of Louisville, have expressed similar views. So it seems that the cycle of abdominal section is drawing to a close. We have had recently in gynecological work several "fads." Sims' cervix splitting, Emmet's operation of trachelorrhaphy, divulsion of the cervix *a la* Goodell, going the way of all "fads." Each of you remember the recent declaration of the elder Keith, whose record in hysterectomy for tumors of the uterus has never been surpassed, that he would make no more hysterectomies, but try Apostoli's method of cure instead.

It may fairly be said that we are now entering on the period of decline in abdominal section, just as all these other "fads" have declined, and in the place of section for these ills of which women are the victims, we are now to have a cycle of electricity—that "mysterious force" which none of us understand. But I predict for it that it will have its period of infancy, in which we are now living, its period of manhood or vigor and old age or decline.

What is to follow I cannot tell, but that something will in turn rise up to take its place I am assured.

The pendulum swings back and forth and ticks off the seconds of time; the cycles or "fads" in medicine and surgery do likewise; but

instead of seconds of time passing to the deep of yesterday, human lives pass to "that bourne from which no traveler returns."

Since writing the above, Wertheim, of Prague read before the German Congress of Obstetricians a paper in which he took the ground that these pelvic or tubal troubles were produced by the gonococcus. In some of the cases he failed to find the coccus in pus from the tubes with the microscope, after careful examination, and yet, in every one of these cases, by using the "plate culture process," the gonococcus was found; and to complete the cycle he took these pure culture gonococci thus obtained from tubal pus, and by inoculation produced, without a single failure, typical blennorrhagic urethritis. What more do we need in the way of evidence that tubal disease, and hence pelvic peritonitis with all its attendant evils, is produced by gonorrhœal infection?

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